THE
VERBENA ASKEW LAW FIRM
A Professional Corporation, 2 Eaton Street, SUITE 708
HAMPTON, VIRGINIA 23669

AUTHORIZATION TO DISCLOSE/RELEASE CONFIDENTIAL HEALTHCARE, ASSOCIATED FINANCIAL ACCOUNTS, AND BILLING INFORMATION

RE: Name: _____

Date of Birth: _____ SSN: _____

I authorize the use or disclosure of the above individual's health information as described below:

1. The following individual, organization or facility is authorized to make the requested use or disclosure:

Provider Name: _____

Provider Address: _____

_____

_____

2. The information may be disclosed to and used by the following individual(s), organization or facility:

Release To: **The VERBENA ASKEW LAW FIRM, P.C.**
2 Eaton Street, Suite 708
Hampton, VA 23669

Reason for Release:____ Legal purposes/personal injury claim

____ At the request of the undersigned individual

3. The specific information that should be disclosed:

A. RECORDS: All records which are specifically requested by my attorney from my date of birth indicated above to the present, including but not limited to : all doctor's notes, notes of office visit, nursing notes(both typed and handwritten), all correspondence, telephone messages, radiology or other diagnostic reports, patient/medical history questionnaires, prescriptions, referral forms, work release/return to work slips, itemized billing statements for all services rendered to me (including CPT codes and payments on account), and any other information requested relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. This consent also authorizes the health care provider to communicate about my health condition with my attorney(s), both orally and in writing.

B.BILLINGS: All information relating to direct and indirect billings and charges for associated services, including financial accounts, health insurance claims and payments and policy and benefits information.

I further revoke any and all authority that may have been previously given to others regarding this matter. This revocation does not include personal health insurance, carriers providing workers' compensation benefits, Medicare, state or federal agencies.

4. I hereby understand that the information used or disclosed may be subject to re-disclosure by the person(s) or organization(s) receiving it, and would no longer be protected by federal privacy regulations.

5. I understand I have the right to revoke this authorization at any time. I understand I must do so in writing and present my written revocation to the appropriate health information management department I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire upon completion, settlement or dismissal of the above referenced litigation. If I fail to specify an expiration date, event or condition, this authorization will expire in 24 months.

6. I understand that the information in health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information disclosed, as provided in CFR 164.524.

8. Statement that treatment and payment may not be conditioned on obtaining this authorization. I fully understand and accept the terms of this authorization.

_____ _____
Signature of Client/Patient Date

_____ _____
Signature of Legal Representative or Guardian Date